



DISPARITIES IN HEALTHCARE QUALITY AMONG RACIAL AND ETHNIC GROUPS



Selected Findings From the
2011 National Healthcare Quality and Disparities Reports

Introduction

Each year since 2003, the Agency for Healthcare Research and Quality (AHRQ) has reported on progress and opportunities for improving health care quality and reducing health care disparities. As mandated by the U.S. Congress in 42 U.S.C. 299, the National Healthcare Quality Report (NHQR) focuses on “national trends in the quality of health care provided to the American people” while the National Healthcare Disparities Report (NHDR) focuses on “prevailing disparities in health care delivery as it relates to racial factors and socioeconomic factors in priority populations.”

Racial and Ethnic Minorities

In 2010, about 41% of the U.S. population identified themselves as members of racial or ethnic minority groups. More than half of the growth in the total population of the United States between 2000 and 2010 was due to an increase in the Hispanic population. By 2050, it is projected that these groups will account for almost half of the U.S. population.

For the 2010 U.S. census data, the Census Bureau reported that the United States had 42 million Blacks or African Americans (13.6% of the U.S.

population); 50.4 million Hispanics or Latinos (16.3%); 17.3 million Asians (5.6%); 1.2 million Native Hawaiians and Other Pacific Islanders (NHOPIs) (0.4%); and 5.2 million American Indians and Alaska Natives (AI/ANs) (1.7%). Almost half of the AI/AN population reported multiple races and 78% indicated that they lived outside of Federal trust land.

Racial and ethnic minorities are more likely than non-Hispanic Whites to be poor or near poor. In addition, Hispanics, Blacks, and some Asian subgroups are less likely than non-Hispanic Whites to have a high school education.

Disparities in quality of care are common:

- Adults age 65 and over received worse care than adults ages 18-44 for 39% of quality measures.
- Blacks received worse care than Whites for 41% of quality measures.
- Hispanics received worse care than non-Hispanic Whites for 39% of measures.
- Asians and AI/ANs received worse care than Whites for nearly 30% of quality measures.



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- ❑ Poor people received worse care than high-income people for 47% of measures.

Disparities in access are also common, especially among Hispanics and poor people:

- ❑ Adults age 65 and over rarely had worse access to care than adults ages 18-44.
- ❑ Blacks had worse access to care than Whites for 32% of access measures.

- ❑ Asians had worse access to care than Whites for 17% of access measures.

- ❑ AI/ANs had worse access to care than Whites for 62% of access measures.

- ❑ Hispanics had worse access to care than non-Hispanic Whites for 63% of access measures.

- ❑ Poor people had worse access to care than high-income people for 89% of access measures.

Largest racial, ethnic, and socioeconomic disparities*

	Relative rate*
Black vs. White	
Hospital patients with pneumonia who received initial antibiotic dose within 6 hours of hospital arrival	1.6
Short-stay nursing home residents who received influenza vaccination during the flu season	1.6
Hospital patients with heart attack who received percutaneous coronary Intervention within 90 minutes of arrival	1.6
Asian vs. White	
Obstetric trauma per 1,000 vaginal deliveries without instrument assistance	1.6
Obstetric trauma per 1,000 with instrument assistance	1.6
Long-term stay nursing home residents with physical restraints	1.5
American Indian or Alaska Native vs. White	
Low-risk long-stay nursing home residents with pressure ulcers	1.6
Adult surgery patients who received prophylactic antibiotics within 1 hour prior to surgery	1.4
Hospital patients with pneumonia who received initial antibiotics consistent with current recommendations	1.3
Hispanic vs. Non-Hispanic White	
Children who had a doctor's office or clinic visit in the last 12 months whose health providers sometimes or never listened carefully	1.6
Adults who needed care right away for an illness, injury, or condition in the last 12 months who sometimes or never got care as needed	1.6
Long-term nursing home residents who were assessed for pneumococcal vaccination	1.6
Poor vs. High Income	
Children who needed care right away for an illness, injury, or condition in the last 12 months who sometimes or never got care as soon as wanted	1.6
People with a usual primary care provider	1.6
Adults age 65 and over who ever received pneumococcal vaccination	1.5

* To determine relative rates (RRs), measures were framed negatively. An RR greater than 1 indicates that a group is receiving poorer quality of care or facing larger problems with access to care compared with the reference group. For example, an RR of 1.5 for receipt of pneumococcal vaccination means that poor adults age 65 and over were 1.5 times as likely not to get vaccinated.

Few disparities in quality of care are getting better.

- ❑ The gap in quality between adults age 65 and over and adults ages 18-44 improved for about one-quarter of the measures.
- ❑ Few disparities in quality of care related to race, ethnicity, or income showed significant improvement although the number of disparities that were getting smaller exceeded the number of disparities that were getting larger.

Barriers to Access to Quality Health Care

Access to care measures include facilitators and barriers to care and health care utilization experiences of subgroups defined by race and ethnicity, income, education, availability of health insurance, limited English proficiency, and availability of a usual source of care.

Health Insurance Status

Overall, there was no significant change from 1999 to 2009. In 2009, about 83% of people under age 65 had health insurance.

- ❑ In 2009, Blacks under age 65 were less likely than Whites to have health insurance (81% compared with 83%), and AI/ANs under age 65 were less likely than Whites to have health insurance (68% compared with 83%). There were no statistically significant differences for other racial groups.
- ❑ In 2009, Hispanics under age 65 were less likely than non-Hispanic Whites to have health insurance (67% compared with 87%).
- ❑ From 1999 to 2009, while the percentage of people with health insurance increased for poor people (from 66% to 70%), the percentage decreased for middle-income

people (from 86% to 82%). In 2009, the percentage of people with health insurance was significantly lower for poor, low-income, and middle-income people than for high-income people (70%, 70%, and 82%, respectively, compared with 94%).

- ❑ In 2009, the percentage of people ages 25-64 with health insurance was about one-third lower for people with less than a high school education than for people with at least some college education (56% compared with 88%).

Specific Source of Ongoing Care

Overall, 86% percent of people had a specific source of ongoing care in 2009.

- ❑ In 2009, the percentage of people with a specific source of ongoing care was lower for Blacks and AI/ANs than for Whites (85% compared with 86%; and 79% compared with 86%).
- ❑ In 2009, the percentage of people with a specific source of ongoing care was significantly lower for Hispanics than for non-Hispanic Whites (77% compared with 88%).
- ❑ In 2009, the percentage of people with a specific source of ongoing care was significantly lower for poor and low-income people than for high-income people (78% and 80%, respectively, compared with 92%).
- ❑ The percentage of people with a specific source of ongoing care was lower for people with less than a high school education and for people with a high school education than for people with any college education (75% and 83% respectively, compared with 88%).

Quality and Access to Care for Populations With Limited English Proficiency

Language barriers in health care are associated with decreases in quality of care, safety, and patient and clinician satisfaction and contribute to health disparities, even among people with insurance. The Federal Government has issued 14 culturally and linguistically appropriate services standards. These standards, which are directed at health care organizations, are also encouraged for individual providers to improve accessibility of their practices.

- ❑ Compared with patients who speak English at home, patients who speak Spanish at home were more likely to report poor communication with nurses while patients who speak some other language at home were more likely to report poor communication with both nurses and doctors.
- ❑ In 2008, Hispanic adults were significantly more likely than non-Hispanic adults to have a usual source of care with language assistance.
- ❑ In 2008, White adults with limited English proficiency were significantly more likely than Asians to have a usual source of care with language assistance.
- ❑ In 2008, non-Hispanic White patients in California were significantly less likely than Hispanic patients to need a translator during their last doctor visit (0.5% compared with 10%). Non-Hispanic Whites were also less likely than Mexicans and Central Americans to need a translator. Asians were significantly more likely than non-Hispanic Whites to need a translator during their last doctor visit (3% compared with 0.5%). There were, however, no statistically significant differences between the overall Asian population and Chinese or Vietnamese patients. There were also no

significant differences between Chinese and Vietnamese patients.

- ❑ Patients in California with less than a high school education and high school graduates were significantly more likely to need a translator than patients with any college education (14% and 3%, respectively, compared with 1%).

Summary

The 2011 NHQR and NHDR emphasize the need to accelerate progress if the Nation is to achieve higher quality and more equitable health care for all Americans in the near future.

Among the themes that emerged from the reports are:

- ❑ Health care quality and access are suboptimal, especially for racial and ethnic minorities and low-income groups.
- ❑ Quality is improving; access and disparities are not.
- ❑ There are several areas where disparities are worsening over time between minorities and Whites and between poor and high-income populations:
 - Maternal deaths in Black population.
 - Breast cancer diagnosed at advanced stage per 100,000 women age 40 and over in Black population.
 - Children 0-40 pounds for whom a health provider gave advice about using car safety seats in Asian population.
 - Adults age 50 and over who ever received a colonoscopy, sigmoidoscopy, or proctoscopy in AI/AN population and in poor population.

- People with difficulty contacting their usual source of care over the telephone in AI/AN population.
- Poor adults who did not have problems seeing a specialist they needed to see in the last year.
- Poor people without a usual source of care who indicated a financial or insurance reason for not having a source of care.

□ Some areas merit urgent attention, including:

- Diabetes care.
- Disparities in cancer screening.
- Access to care health insurance and a usual source of care.

For More Information

The 2011 NHQR and NHDR are available online at www.ahrq.gov/qual/qrd11.htm.

To learn more about the mission and activities of AHRQ's Division of Priority Populations, please visit the AHRQ Web site at www.ahrq.gov/populations. For information and/or questions about specific activities related to priority populations, you may contact us at: Prioritypops@ahrq.hhs.gov

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